Workgroup D: Workforce Development
Rationale for Recommendations
Presented to the Governor's Task Force on January 10, 2005

Introduction

Workgroup D changed its original workforce development charge to call upon the state's long-term care policies to "build and sustain culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

The key differences from the original principle include:
1. The recognition that "teams" play a critical role in the delivery of care and supports. Teams may be comprised of a simple dyad such as an individual hiring directly one person or larger teams of an individual and extended family working with a multi-disciplinary team of trained, compensated caregivers.
2. The recognition of a diverse workforce serving a diverse population.
3. The group decided to seek a "competitively" compensated workforce to acknowledge the need for reimbursement systems, particularly public ones, to allow long-term care providers to offer competitive compensation packages. The principle also attempts to address the disparities of compensation packages offered all kinds of paid caregivers within long-term care and across all of health care.
4. The group decided to include the concept of a "supportive environment" to acknowledge the need to change workplace practices and cultures.
5. The group decide to include the concept of responsiveness to "consumer needs and choices" to ground recommended activities in the overall goals of a consumer-centered system.

Over 400,000 individuals work in Michigan's health care system. Michigan will create thousands, not hundreds, of new jobs in long-term care every year for the foreseeable future. Health care, generally, and long-term care are major elements of the state's economic and workforce engines. Not only does long-term care provide vital services to citizens but allows family members to work in other sectors.

With Task Force discussions about how to better integrate long-term, primary and acute care, the workgroup voted to define the long-term care workforce and

to acknowledge a general "focal points" for its workforce recommendations. Our recommendations seek to focus activities on those individuals with "the closest relationship" to consumers. Our intent is not to diminish any member of the "team" but to put a spotlight on those members of the teams that consumers report are the most critical and necessary to quality and satisfaction.

The recommended definition is "the Long Term Care Workforce is made up of paid and unpaid individuals and agencies that provide direct care and/or supportive services across the continuum."

The "focal point of the recommended strategies is those paid and unpaid individuals in the long-term workforce with the closest relationship with the consumer. That relationship is to be empowered to provide high quality services surrounded by supportive supervision, cultural sensitivity, access to multi-disciplinary resources, effective management, strong leadership and social commitment." The workgroup believes that activities should begin first with direct care workers, licensed nurses and social workers as those "closest" to consumers. Recommendations are also made relative to other members of the long-term care team.

Workforce projections

The long-term health care sector faces systemic challenges to attract and retain a qualified workforce. Long-term care, unlike many other business sectors, creates more jobs consistently every year. These newly created jobs can require years of formal training and preparation or relatively brief training and preparation periods. LTC jobs are located in every neighborhood and community in the state.

Key projections about the growth of jobs within the health care sector that motivated the workgroup's deliberations come from a variety of sources including the U.S. Bureau of Labor Statistics (Hansen, 2004) and include:
1. A variety of health related industries and occupations are increasing in size and scope, such as "community care facilities for the elderly, residential care facilities, and ambulatory health-care services…and are listed among the top 10 fastest growing industries in the next ten years "
2. The fastest growing health care occupations are Medical assistants (59%), Physician assistants (49%), and Home health aides (48%). However, an additional 10 health occupations [RNs, LPNs, nursing aide, and personal care attendant] are projected to grow by 47 to 35%.

3. In addition, the BLS predicts growth for a number of other health professions, such as audiologists, dentists, etc.

4. Predictions of future shortages can be estimated according to the percentage of current employees by age groups, revealing that for direct care workers, RNs, and LPNs, there are not enough new workers entering the field to replace workers who will soon be retiring.

5. Michigan ranked 42nd [50th is the lowest rank] among states in social workers per capita. The finding has specific relevance for a Single Point of Entry system, as well as for care management services by social workers (e.g., MI Choice program).

For its entire work life, the workgroup attempted to quantify the number and categories of jobs/individuals in Michigan's serving consumers in a close relationship in keeping with our agreed "focal point." Except for Medicaid certified nursing homes and the Home Help program, we were largely unsuccessful. While the federal Bureau of Labor Statistics can outline occupations, Michigan has not mined the data to explain how many of the jobs are in long-term care versus schools, hospitals, and other businesses.

As outlined in more detail in the attached "Final Workforce Projections Report" researched and written by Rosemary Ziemba, Ph.D. we cannot report for the LTC sector the number of existing jobs, the existing vacancies, the compensation package offered, and other meaningful workforce data with any certainty for the state's 4,000+ licensed adult foster care homes, 184 licensed homes for the aged, or 200+ certified home health care agencies.

Similarly, we cannot even report a meaningful estimate or guess of the number unlicensed "assisted living" organizations and all home care agencies in the state. We could not find or create credible methods to estimate the number of assisted living residences or the number of home care agencies, the numbers of people served, or their workforces.

A recent joint report issued by the state departments of Labor and Economic Growth and Community Health focused on projections for a large sample of licensed health occupations. Many of the report's findings are relevant to the LTC workforce with two major distinctions: 1) the DLEG/DCH report does not address workforce projections for direct care workers, the largest employee group in LTC; and 2) the DLEG/DCE report does not distinguish between the acute care and long term care employment sectors. The DLEG/DCH report implies a concentration on acute care settings, such as hospitals.

Specific recommendations are made to address this data void and its implications for planning. While these recommendations appear last in the report, a continued void in understanding the number and types of available jobs, the demographics of the current workforce, and with individuals come to and leave these jobs will continue to marginalize this health sector. The lack of concrete information about the LTC workforce dynamics spanning the continuum means less informed decision-making and activities.

Disability rates

Similarly, the workgroup attempted to quantify existing rates of disability/need for services/care as well as projections for those rates for Michigan. We were unsuccessful in this endeavor as well. While age may have a positive causal relationship to disability and needed for services, we believe that better data is need to project workforce needs as well as service needs. Specific recommendations are made to address this data void.

Recruitment

Based on available data, more jobs will be created within the long-term care sector. The state needs to change its policies to aide LTC employers of sizes in recruiting capable, motivated, competent individuals into these jobs. Through federal Workforce Investment Act funds and Welfare-to-Work programming, Michigan has resources and opportunities to encourage and support those who are "called" to this work or to serve the elderly or people living with disabilities.

Retention

At the same time more people are newly recruited to the field, thousands of people leave a specific job in long-term care every year for a different job in long-term care, primary or acute care, or for a different business sector. While job "turnover" can never be eliminated, most long-term care employers of all kinds sustain turnover rates in most jobs sectors in excess of normal rates for service sector businesses.

The costs of turnover have been outlined in the recent study "The Costs of Frontline Turnover in Long-Term Care" by labor economist Dorie Seavey, Ph. D. She estimates that, across the LTC sector, direct costs for each replacement averages $2500 and indirect costs are $1,000. A 65% turnover among the state's 21,500 CNAs in Medicaid nursing homes incurs annual costs of almost $49 million annually. Similar turnover rates in assisted living and home care waste millions more of public and private resources. (The full turnover cost report is available at www.bjbc.org.)

Explanations for the excessive rate of turnover within Michigan's long-term care system are not well documented but for certified nursing assistants and home care aides through the survey "Voices from the Front: Recruitment and Retention of Direct Care Workers in Long Term Care across Michigan." The study finds that the strongest predictors for leaving direct care work are low wages, household poverty, and poor relationships with supervisors as well as workload, and not feeling valued by an employer.

Nationally, research explains that low wages and benefits, hard working conditions, heavy workloads, and a job that has been stigmatized by society make recruitment and retention difficult. (US Dept. of Health and Human Services Who Will Care for Us?) While the Voices from the Front report finds that "available training" attracts 40% to the work, the state has very little infrastructure for training direct care workers outside of the federally mandated CNA approved training programs. Career paths and ladders are not formally supported or encouraged by state policies. (Taylor, 1998).

The workgroup has made specific recommendations to improve educational programs for direct care workers and licensed nurses, to change the workplace supervisory approaches, to reduce injuries, and to provide supports to remove employment barriers for low-wage LTC workers.

Compensation

The package of wages, salary, health care coverage, retirements and other benefits offered LTC employees are rarely competitive with other health care employers. Direct care workers in facility-based settings and in home care services are rarely paid a "self-sufficient" wage [Michigan League for Human Services] that will support the basic needs of a family. In Michigan, one in three home health care aides has a second job and one in five certified nursing assistants has a second job. (*Voices from the* Front April 2004). Because of the part-time nature of their jobs, many home care workers are not offered health insurance coverage for themselves or their dependents. Nurses in LTC generally earn 20% less than their colleagues in primary care settings. (Institute of Medicine report, *Improving the Quality of Long-Term Care,* 2001)

While better compensation is not the single answer to workforce needs, it is an essential element to attracting and retaining a qualified team of individuals. The absence of team members will very likely mean that services needed and publicly authorized for consumers will not be delivered.

The workgroup has made specific recommendations—both short term and long term—to address the compensation issues.

Culture change

During the workgroup's deliberations, the status and image of long-term care became a vocal point of discussion of workforce issues. The negative images of aging and disability undoubtedly play a role in the negative image of the sector and ultimately, the people who use the services and the people who work in long-term care.

At the same time, there was universal agreement that the "hierarchal medical model" of management and service delivery used in health care delivery systems is not appropriate for consumer or employee interests. A top-down management culture does not foster problem-solving for those "closest to the consumer" who are likely to be at the bottom of a traditional organizational chart.

As a result, the workgroup recommends two types of culture changes in spite of the likely difficulties of fostering culture change through government activities and policies.

Long-term care—all of it, the entire continuum of services---must be seen and treated by state policies as a valued health service and a valued tool for economic and community development for families and communities. And, all the people who work for long-term care employers—whether individual consumers or multi-national corporations—must be seen and treated by state policies as valuable, essential contributors to the state's mission to provide quality supports and care to its citizens.

Long-term care organizations—large and small—must embrace new participatory management and delivery systems that are consumer-centered and worker-friendly. Within the constant of person-centered care, team work that fosters real communication and partnerships among consumers and all caregivers is essential. New practices in nursing home and elder care— Wellspring, Greenhouse, Gentle Care, Eden Alternative, LEAP and others springing from the creativity and dedication of organizational leaders—should be supported by state policies.

The workgroup has made specific recommendations for societal and organizational culture change.

Alternative Value Statement/Principle

Workgroup D has rewritten its originally assigned Visions and Values Statement/Principle as well as creating a definition of "the long-term care workforce" and focal point for activities. We recommend adoption by the Task Force of the altered Statement, the definition and focal point for activities.

Original Principle: Builds and sustains an adequate, well-trained, highly motivated, and appropriately compensated workforce across the long-term care continuum.

Recommended Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Agreed Workforce Definition: The Long Term Care Workforce is made up of paid and unpaid individuals and agencies that provide direct care and/or supportive services across the continuum.

The focal point of the recommended strategies is those paid and unpaid individuals in long-term workforce with the closest relationship with the consumer. That relationship is to be empowered to provide high quality services surrounded by supportive supervision, cultural sensitivity, access to multi-disciplinary resources, effective management, strong leadership and social commitment.

Workforce Projections: Final Report

INTRODUCTION

This is the final report of workforce projections for long term care in Michigan. Special thanks to all those who contributed data, resources, and comments: Carol Garlinghouse, Beverly Takahashi, Elizabeth Janks, Susan North, Kathy Flowers-McGeathy, Howard Schaeffer, Melanie Brim, Michelle McGuire, Jill Hess, Lauren Swanson, Pat Anderson, Dave Reusser, Deborah Woods, Lynn Zuellig, and several Area Agencies on Aging.

The basic charge of the Governor's Medicaid Long-term Care Reform Taskforce was to develop home and community based alternatives to nursing homes for people of all ages with disabilities. In this document, the current and projected long-term care (LTC) workforce is described across a range of settings from home care, congregate care, and nursing home care. Workgroup D established the following definition of the LTC Workforce:

- **The Long Term Care Workforce is made up of paid and unpaid individuals and agencies that provide direct care and/or supportive services across the continuum, as chosen by the consumer.**

   The focal point of the long-term workforce is the relationship between the consumer and the direct caregiver that is empowered to provide high quality services surrounded by supportive supervision, cultural sensitivity, and access to multidisciplinary resources, effective management, strong leadership and social commitment.

Although preliminary data focused on direct care workers, nurses, and social workers based on current and projected shortages, it is apparent other occupations, such as pharmacists, and other professionals also face shortages according to a recent report prepared for the Michigan Department of Labor & Economic Growth (**Public** Policy Associates Inc**.,** 2004)**.** The preliminary report on Workforce Projections consisted of several documents :

A. **Workforce Projections: Preliminary Report**
B. **Figure 1: Aging Projections, Michigan & US; & Figure 2: Projection of LTC Population in Michigan**
C. **Bureau of Labor Statistics: Issue Brief, US Health Workforce Projections 2002-2012.**
D. **Excerpts from the HRSA State Health Workforce Profile: Michigan, 2000.** Occupations by setting are depicted in several pie charts and graphs. [The complete HRSA report and HRSA's two-page "highlights" can be found on the LTC website (http://www.ihcs.msu.edu/ltc)].

This final report has additional data obtained from workgroup members regarding service use and workers per category across various LTC settings.   In addition, information was incorporated from a recent report (October, 2004) produced by the Michigan Department of Labor and Economic Growth (Public Policy Associates Inc., 2004).

1. WORKFORCE PROJECTIONS
The Michigan Department of Labor & Economic Growth
Report on Health Care Workforce in Michigan

DLEG and DCH recently issued a health care workforce report on Michigan concurrent with the award, by DLEG, of funding for regional skills alliances for healthcare employers. Unfortunately, the report does not address workforce projections for direct care workers, nor does it distinguish between the acute care and long term care employment sectors. In essence the report implies a concentration on acute care settings, such as hospitals.

Health occupations fill an important sector of Michigan's economy, representing the State's largest industry. Health care employment provides $17.7 billion per year in wages and benefits in Michigan contribute to local economies (Public Policy Associates Inc., 2004). Shortages exist for several well-paid occupations in professional and technical categories. **(Public Policy Associates Inc., 2004).** The full document is posted on the DLEG website**.**

The perspective of the DLEG report may be an example of the misunderstood, under-appreciated and unrecognized complexity of the long-term care industry, which covers a diverse array of services, provided over sustained periods of time.

Long-term care includes both *health* care and *social* care in different ratios, depending on the support needs of the care recipient. Strict philosophical divisions between "medical models" and "social models" obscure the reality that many people needing long-term care require medical treatment as well as social support to achieve and maintain quality of life (IOM, 2001). For example, Hospice coordinates services by a multi-disciplinary team in order to manage symptoms, promote quality of life, and meet the progressive needs of the terminally ill and their families. Persons with progressive, debilitating or chronic disease--whether at home, in nursing homes, or in other congregate facilities--will require both ADL and IADL support as well as health monitoring and intervention to ensure quality of life and quality of care.

Data on quality indicators in various LTC settings is not as established as in acute care and nursing home settings. However, in those settings, quality is related to the presence of personnel with advanced education and training (IOM, 2001**).**

Thus, LTC workforce projections must take into account organizational models for service delivery, the composition of support teams, and the relationship among multiple team members. In addition, due to the higher wages and better benefits offered

in the acute care sector, efforts to recruit and retain adequate numbers of qualified staff are further challenged. The remainder of this report differs from DLEG's Health Care Workforce report by providing additional emphasis on the LTC sector, and accordingly, the direct care workforce.

LTC Workforce Projections

There is a chronic, severe, and growing shortage of direct care workers—the hardest workers to recruit and retain—in all settings, especially in home care. "Of the 88,340 new jobs created in Michigan from 1999 to 2000, 10 percent were direct-care jobs" (National Clearing house on the Direct Care Workforce, State Activities, Michigan. Online). A severe shortage of DCWs is supported by data from many sources (IOM, 2001; Janks, LeRoy, & Lasker, 2004; Turnham & Dawson, 2003); as many as 40,000 DCWs may be needed by 2010 (Janks et al., 2004). Shortages are predicted in other occupations as well.

Key findings from the U.S. Bureau of Labor Statistics (Hansen, 2004) include:

6. A variety of health related industries and occupations are increasing in size and scope, such as "community care facilities for the elderly, residential care facilities, and ambulatory health-care services…listed among the top 10 fastest growing industries in the next ten years "

7. The fastest growing occupations are Medical assistants (59%), Physician assistants (49%), and Home health aides (48%). However, an additional 10 health occupations are projected to grow by 47 to 35%.

8. Health occupations with the largest job growth for 2002-2012 are RNs, nurse aides, home health aides, personal care aides, and medical assistants. In addition, the BLS predicts growth for a number of other health professions, such as audiologists, dentists, etc.

9. Predictions of future shortages can be estimated according to the percentage of current employees by age groups, revealing that for direct care workers, RNs, and LPNs, there are not enough new workers entering the field to replace workers who will soon be retiring.

10. Home health aide employment is projected to increase by 36.1%; "Michigan ranked 42nd [50 is the lowest rank] among states in social workers per capita." The finding has relevance for a Single Point of Entry system, as well as for care management services by social workers (e.g., MI Choice program).

Workforce Needs by Service Groups and Settings

Beneficiaries of Medicaid LTC services come from all generations across the lifespan and are a diverse group. There are several (and sometimes over-lapping) service populations: the elderly; the disabled of any age; the chronically ill; those with

development disabilities; those in recovery from a serious and acute health event; and people with terminal illness.

The needs of the elderly are predicted to increase substantially due to the "silver tsunami" on the near horizon as the baby boom generation enters retirement. In 2005, 12.4% of Michigan's population will be $\geq$ 65 years old; that proportion will grow to 16.2% by 2020 (See Figure 1, Aging Projections).

The total LTC population in Michigan is currently estimated at 168,000 people, and is projected to increase to 219,484 by 2020 (Figure 2: LTC projections). The oldest-old ($\geq$80years) is the fastest growing segment of the U.S. population. With age, incidence of disability and chronic conditions increase. A little more than 10 percent of Michigan's population aged 16-64 has a sensory, physical, mental, or self-care disability, compared to 37.1% of people < 65 (US Census Bureau, Census 2000).

Data (usage and costs) across multiple settings (nursing homes, AFC and HFA, unlicensed assisted living residences, and home care) are tabulated in this report. However, the age diversity of the service population of Medicaid beneficiaries is not always apparent in the data. For example, Adult Foster Care homes and nursing homes serve adults of all ages, but ¾ of AFC residents are 65 or over.

Some fear that the increasing size of the population of older adults will overshadow the unique needs of smaller service groups, particularly children and adults with developmental disabilities.

The biggest gap in services as well as in funding is for people with developmental disabilities in their adult years—18 to 45. There is a dearth of DCWs for this service sector, and virtually no programs of financial support.

In the following table, attempts have been made to quantify the current numbers of personnel across settings. However, caution is advised in citing or interpreting the figures since some are estimates, and some are extrapolated from national data. Because of the use of multiple sources to derive some statistics, groups might not be exclusive of each other (i.e., some people may be counted twice).

The most significant finding in attempting to produce this table is that the data for several LTC settings is very hard to find, and further, coordinated efforts to collect accurate data are needed. For example, no data or statistics are kept by the State on personnel in AFCs or HFAs. The number of certified home care agencies is available (although that number might also include agencies in Ohio that provide service to Michigan residents). Data on non-certified home care agencies was not available; only partial data from several Area Agencies on Aging was obtainable in this short time period. Some AAAs provided a count of non-certified agencies that they use, but these agencies might be providing services to more than one AAA.

Table 1: Long term Care Settings in Michigan and staffing levels (FTE's)

Setting	Facilities	Capacity	DCW FTE	RN FTE	LPN	DON/ ADON	SSDIR/ SS staff
Nursing Homes	446	49,294	21,529	3,319	5,883	497/ 188	208 832
AFC Homes* Family Homes	1,225	5,725	Not available				
Small group	1,917	10,956					
Medium group	622	6,723					
Large group	496	9,192					
Congregate	13	483					
County Infirmary	2	96					
Homes for the Aged	184	14,138	Not available				
Unlicensed assisted living (estimated)	***	Not available					
Home care Certified Agencies	236						
Non-certified Agencies	***						
Home Help TOTAL Family members		51,567 (28,751)	51,567 (28,751)				
MI Choice Waiver		9,000					
Certified Hospice Programs							
Unpaid family members	134	(2 million)					

*10/1/2003-8/31/2004   *** as these facilities are unregulated it is not feasible to provide meaningful figures.

Additional data on DCWs:

As of October 1, 2004 there are 121,378 names on the Certified Nurse Aide registry. Only 41,307 are currently "active" meaning they have continued to renew their certification through a fee and continuing education. In some cases an individual may have been "flagged" due to past mistreatment, or abuse or misappropriation of a resident and be unable to be employed in nursing homes. 695 individuals on this registry have been "flagged".

Additional Data on paid Home Help providers:

Family members:	28,751
Non-relative (or independent contractors):	21,402
Agency employees:	1,414
TOTAL	51,567

Additional data on Home Care Agencies:

There are 195 certified and hospice memberships (voluntary membership), and 62 private duty agencies in the Michigan Home Health Association.

Medicare/Medicaid licensing data show 221 home health agencies, and 79 hospice agencies. This includes out-of-state agencies authorized to serve Michigan Medicare recipients. The number of hospice residences is unknown. There is no

information on FTE for home health care agencies; the total number of private (non-certified) agencies is unknown.

Partial data on non-certified HHA utilized by AAAs:

Region 9:	14
Region IV:	18 (out of 21 home service providers)
Region 2:	9 ("at least")
Region 7:	19 (out of 32)
Upper Peninsula:	26 (6 of these are non-certified "sister agencies" of certified HHA)
Region 3A:	19
Region 10:	20 (out of 22)
TOTAL	125

Please note that the total of non-certified HHAs is flawed since some agencies may be serving more than one AAA, and further inquiry is needed for the remaining 9 AAAs, and three other waiver agents. Also, AAA directors responded that these were only the agencies they had contracts with; there were others in the community. And as one person said, "there are new ones all the time."

TABLE 2: TOTALS OF WORKERS AND ESTIMATES BY SETTING

Numbers per setting have been calculated based on the total number of workers per category as reported by the HRSA report for Michigan (HRSA, 2000).

	TOTALS	% IN NH & EXTENDED CARE
RNs	78,310	9%* (7,048)
LPNs	17,440	34.8% **(6,069)
SW	17,030	
HOME HEALTH AIDES	14,490	NOT APPLICABLE
NURSE AIDES, ORDERLIES AND ATTENDANTS	40,640	??

* % ACCORDING TO EAST NORTH CENTRAL CENSUS DIVISION DATA
** % ACCORDING TO U.S. FIGURES

DIRECT CARE WORKERS

The highest rates of turnover are among direct care workers (IOM, 2000), averaging 65.6% in Michigan (Turnham & Dawson, 2003). In 1998, the turnover rate for aides in nursing homes was 75% in Michigan (Michigan's Long Term Care Work Group, 2000). Turnover is expensive to facilities and produces a lack of consistent caregivers for beneficiaries of service (Turnham & Dawson, 2003).

Poor wages and benefits, difficult working conditions, high patient to DCW ratio (in congregate settings) are major reasons for DCW job dissatisfaction. Median hourly wage in Michigan is $7.75 for home care aides and $8.52 for NH or other settings (HRSA, 2000). There is a considerable wage gap between DCWs and members of the

health professions. With concern for building an effective team, we need to emphasize the poverty level statistics on DCW, including the lack of health insurance, and a large work-injury rate (Turnham & Dawson, 2003). In comparing the nation's DCW workforce of the 1980s with the 1990s, Yamada (2002) found that while there have been some improvements overall, work conditions for home care aides are poorer than for other DCW groups. Many aides live at (16-22%) or near poverty (25-29%). The most negatively affected are home care aides (Yamada, 2002). In Michigan, close to half of DCWs live at or near (within 200%) of the poverty level for a family of four (Mickus, Luz, & Hogan, 2004). Up to a third of DCW meet income eligibility for Medicaid.

A common finding in several studies is that poor relationships with supervision and management are leading causes of job dissatisfaction among DCWs (IOM, 2001; Janks et al., 2004; Mickus et al., 2004). For example, participative-management strategies increase retention rates of DCW in nursing homes (Yeatts, Cready, Ray, DeWitt, & Queen, 2004). DCW turnover is lowest in settings where turnover of nursing and administration is low (Brannon, Zinn, Mor, & Davis, 2002; IOM, 2001).

RNs & LPNs

RN turnover for all LTC settings in US is 28-59%; 27-61% for LPNs (Reinhard, Barber, Mezey, Mitty, & Peed, 2002). The nursing shortage (nationally) is expected to grow to 29% by 2020 (compared to 6% in 2000)(HHS, 2002). Baseline supply of RNs in 2005 in Michigan is estimated at 72,400, which is slightly over the estimated demand (71,300). However, the projected demand from 2000 to 2020 increases by 25%, while the supply decreases. By 2020, only 78% of the demand will be met (Biviano, Tise, Fritz, Dall, & Grover, 2004). In Michigan, the average age of active RNs is 45 years old, and 31% of all RNs and almost 33% of LPNs plan to work in nursing for only 1-10 more years (Michigan Center for Nursing, 2004).

Nursing has experienced periodic shortages over the last 100 years, but the current nursing shortage has been sustained and is the longest in duration in the last century. There have been recent increases in nursing school applications and enrollment. However, there is also a shortage of nursing faculty. In addition, the profession is still threatened (in acute care settings) by issues such as mandatory overtime, and in all settings, risk of unpaid overtime, along with increased responsibilities of supervising untrained assistive personnel. The acuity of patients in acute care and long term care has increased, but staffing generally has not.

Issues relevant to team building, management and supervision

RNs and LPNs receive relatively little education on supervision and management of DCWs in their basic programs, or on LTC administration in general (IOM, 2001). Although working with unlicensed assistive personnel (e.g., DCWs) is an increasing issue for nurses, there is a significant gap in the literature regarding problems or issues encountered by nurses and others responsible for DCW supervision.

SOCIAL WORKERS

Michigan is one of the lowest ranking states in the U.S. in the ratio of social workers to population. Estimates are needed of personnel needed to implement Single Point of Entry assessments and guidance about options. Care management is provided by social workers, often in conjunction with registered nurses.

3. QUALITY OF CARE

Workforce development consists not only of numbers of staff needed. For quality care to be delivered, workers need to have appropriate levels of education and demonstrate competence.

Educational issues: Training and preparation of DCW

DCW groups, as well as consumer and advocacy groups have identified a need for more training for DCW, in a variety of areas, including life-management skills, communication skills, needs of the elderly, working with people with dementia, avoiding self-injury, and recognizing emergency and urgent situations that require additional intervention. Training needs may vary across settings, and there may be conflict between practice models. That is, personal home care aides are sometimes viewed as independent contractors who are hired and trained by the consumer. In this model, no common training needs are assumed, only those specific to each individual situation.

However, DCWs function in a variety of settings, with varying degrees of mandated training. Overall, DCW educational background regarding health conditions and their treatment and symptoms is low. For example, only 16 hours of training is required for DCW in Adult Foster Care homes. Certified Nurse Aide training (CENA) consists of 75 hours of training. In nursing homes and some assisted living settings, in-service is ongoing. CENA training is not required for Homes for the Aged. Unlicensed assisted living is completely unregulated.

There is a large gap in education levels of DCWs and other team members. While most DCWs have graduated from high school, and a third in Michigan have some college level coursework (Mickus et al., 2004), on-the-job training is often impeded by low literacy levels. The education gap is of concern due to the levels of literacy, training, and knowledge necessary for particular jobs, such as emergency response, medication management, dementia care, and others. The education gap affects the quality of care as well as the communications between team members, including consumers and families.

The education gap is a great concern since a common response to staff shortages and personnel costs is to delegate functions from more highly-paid (and educated) professionals to DCW level staff.

Support for Older Adults

In addition to the educational needs of DCW, there is a problem with a lack of training among all professionals concerning the unique needs of the elderly and persons with disabilities or chronic illnesses. Despite the identification of the unique problems of the elderly, and the differences between them and younger adults, there are few professionals (nurses, physicians, etc.) with the appropriate training to diagnose and intervene appropriately. Although "over 48% of hospital patients, 80% of home care patients, and 85% of nursing home patients are elderly", most nurses practicing today have limited preparation on the unique needs and physiology of older adults (AACN, 2000). Free-standing courses on geriatrics are rare in RN and LPN curricula. There is limited content on the range of long term care alternatives.

"To inadequately trained clinicians, some normal aspects of aging can appear as manifestations of disease while other changes can mask early signs of illness…..To

differentiate disease from normal aging requires assessment skills developed specifically for the older adult and an understanding of the aging process, as well as an understanding of the factors that produce altered sensations of several illnesses" (Amella, 2004).

Support for People with Disabilities
Rehabilitative philosophy and techniques are virtually absent from the curricula of many health professions. Most health professions programs are dominated by an acute care model, and offer little training in rehabilitative care, long term care, and unique needs of people living with disability.

"Traditional medical training places little emphasis on dealing with disability, offering inadequate clinical experience to prepare medical students to provide comprehensive and culturally competent care for people with disabilities " (Kaye, 2001p. 5). There is also widespread ignorance regarding the benefits and correct usage of assistive technology (and limited funding for purchase of assistive technology).

Support for Children with Disabilities
There are unmet needs for home and community based care for children. Many home care providers may be more familiar with providing care to older adults and agencies or programs may lack adequately trained personnel for taking care of children (IOM, 2001).

Kids Count Data 2003 states that there are 247,762 students in special education in Michigan. This accounts for 14.3% of the total school population. There are 32,618 children receiving SSI benefits, this is approximately 12.7% of the children population of Michigan. Kids count has a web page link on the Michigan league for Human Services web page: milhs.org.

Summary
In order to provide true alternatives to nursing homes and a range of choices including home care and congregate settings, improvements are needed to produce an adequate workforce.

The most urgent need across settings is to increase wage, benefits, and training for DCWs. There is a persistent and growing shortage of nurses. There are not enough social workers and nurses to provide single point of entry counseling based on current numbers. Additional action is necessary to provide effective DCW management and team support, including measures to reduce the shortage of nurses and social workers.

A multi-disciplinary team is needed to meet the complex and unique needs of individuals served throughout the LTC system. The team's composition is shaped by the unique needs of the person at the center of care. There are numerous job opportunities across a range of professional and paraprofessional occupations.

Recruitment to almost all LTC job prospects is hampered by a cost and benefit differential (with acute care settings) of about 20%.

Future service needs of the elderly or the disabled cannot be based entirely on past or current usage. While people (on average) are living longer, they are living healthier for longer periods of time, and with lower levels of dependency. The life expectancy gap between men and women is closing, and more couples are living into their 80's and 90's. Trends to change the nursing home environment are also gaining support. Allowing for innovation and advances in treatment, new alternatives are on the horizon.

CONCLUSIONS AND POLICY IMPLICATIONS

Available data were used to create Tables 1 & 2, either through extrapolation from national data, or through estimates provided by State and selected agencies. There are many gaps in the data. A baseline account of current staff is lacking across settings. It was difficult to find comprehensive and clear data about the numbers and types of employees in Michigan AFC homes, home care (whether or not certified), Homes for the Aged, and unlicensed assisted living residences.

- Without baseline data and ways to track changes, it will be difficult to evaluate need, capacity to respond, and success of interventions to reduce turnover. Data on nursing home clients and staff were the most readily available, but persistence was required by State departmental staff to synthesize data across sources, and there is overlap across categories (meaning that employees & recipients might be included in two or more categories).

    Therefore, the State should evaluate ways to collect data on the workforce across all LTC settings, in conjunction with or in addition to DLEG activities related to the Health care workforce in general (see Public Policy Associates Inc., 2004).

- A shortage of LTC workers is evident across categories, with the greatest wage, benefits and education gap for direct care workers (DCWs). Turnover is highest for DCWs, but is severe in additional LTC professions, primarily nursing, and in administration. Knowledge gaps were noted across service settings, in both paraprofessional and professional categories, regarding gerontology and rehabilitative medicine.

    To fully implement SPE, estimates of required personnel are needed. The number of social workers in Michigan is very low compared to other states.

- Economic forecasts are that the demand for all health occupations will increase, and that many of these occupations offer more than a living wage, and represent an economic resource to Michigan. However, to increase the numbers of DCWs able to take advantage of entering into these professions, significant investment is needed in DCW education, training, and resources to facilitate advancement such as adequate wages and benefits.

- The emphasis on LTC projections is on needs of the elderly since the elderly represent the biggest user group of LTC. The needs of the elderly appear to overshadow attention to other groups, such as the developmentally disabled, young and middle-aged adults

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with disability, and adults with chronic or terminal illness. There are many common needs across service groups, such as available and qualified DCWs, preference for home care, and respite for family caregivers. However, the least information and the fewest services are available for adults with developmental disabilities.

For More Information:
- The National Center for Health Statistics—a new release of data in the Data Warehouse on Trends in Health and Aging
  http://www.cdc.gov/nchs/agingact.htm
- National Clearinghouse on the Direct Care Workforce.
- ANCOR American Network of Community Options and Resources
>> www.ancor.org
>>
>> Caregivers and long term care needs in the 21stcentry: will public policy meet the challenges?
>> ltc.georgetown.edu
>> e-mail...rbf4@georgetown.edu
>>
>> PAS Center for Personal Assistance Services
>> www.pascenter.org
>>
>> Issues in the Direct Support Workforce and their Connections to the
>> Growth, Sustainability and Quality of Community Supports
>> www.self-determination.org or contact Amy Hewitt http://rtc.umn.edu
>>
>> Policy brief: Wages of direct Support Professionals
>> http://www.ici.umn.edu/products/prb/142/default.html
>>
>> U.S. Dept of health and human services- RECENT FINDINGS ON FRONTLINE LONG TERM CARE WORKERS
>> May 2004
>> http://aspe.hhs.gov/daltcp/home.shtml
>>
>>
>> The Future Supply of long-term care Workers in Relation to the Aging Baby Boom Generation
>> Report to Congress May 14, 2003
>> http://aspe.hhs.gov/daltcp/reports/ltcwork.pdf

Cited References

AACN. (2000). *Older adults: Recommended baccalaureate competencies and curricular guidelines for geriatric nursing care*: American Association of Colleges of Nursing (AACN) & The John A. Hartford Foundation Institute for Geriatric Nursing. On-line:http://www.hartfordign.org/research/studyPublication/compResource.

Amella, E. J. (2004). Presentation of illness in older adults. *American Journal of Nursing (AJN), 104*(10), 40-52.

Biviano, M., Tise, S., Fritz, S., Dall, T. M., & Grover, A. (2004). What is behind the H.R.S.A.'s projected supply, demand, and shortages of registered nurses? National Center for Health Workforce Analysis. Bureau of Health Professions.

Health Resources and Services Administration.

Brannon, D., Zinn, J. S., Mor, V., & Davis, J. (2002). An exploration of job, organizational, and environmental factors associated with high and low nursing assistant turnover. *The Gerontologist, 42*(2), 159-168.

Hansen, M. M. (2004). Issue brief: Health workforce projections 2002-2012. August 2004. In Center for Health Workforce Planning, Bureau of Health Care Access & Iowa Department of Public Health (Eds.).

HRSA. (2000). *HRSA state health workforce profiles. Michigan*.Rockville,MD: U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions. Online: www.ihcs.msu.edu/ltc.

IOM. (2001). *Improving the quality of long-term care.*Washington, DC: National Academy Press/Institute of Medicine.

Janks, E., LeRoy, B., & Lasker, R. (2004). *A hand for their hands: A report on the empowerment education training initiative for direct support professionals*.Detroit, MI: Developmental Disabilities Institute, Wayne State University.

Kaye, H. S. (2001). *Disability watch: The status of people with disabilities in the United States, volume 2.*Oakland, CA: Disability Rights Advocates.

Michigan's Long Term Care Work Group. (2000). *Long term care innovations: Challenges and solutions*.Lansing, MI: Michigan Department of Community Health. Online: http://www.ihcs.msu.edu/ltc.

Michigan Center for Nursing. (2004). *Survey of nurses 2004*:Michigan Center for Nursing. Online: http://www.michigancenterfornursing.org.

Mickus, M., Luz, C. C., & Hogan, A. (2004). *Voices from the front: Recruitment and retention of direct care workers in long term care across michigan.*East Lansing, MI: Michigan State University.Online:www.miseniors.net.

Public Policy Associates Inc. (2004). *Health care workforce development in Michigan: Final report.*Lansing: Michigan Department of Labor and Economic Growth.

Reinhard, S. C., Barber, P. M., Mezey, M., Mitty, E. L., & Peed, J. A. (2002). *Initiatives to promote the nursing workforce in geriatrics: A collaborative report. February, 2002.*Online: http://www.hartfordign.org/resources/policy/papersBriefs.html: Hartford Geriatric Nursing Institute.

Turnham, H., & Dawson, S. L. (2003). *Michigan's care gap: Our emerging direct-care workforce crisis.*Bronx, NY: Paraprofessional Healthcare Institute.

Yamada, Y. (2002). Profile of home care aides, nursing home aides, and hospital aides: Historical changes and data recommendations. *The Gerontologist, 42*(2), 199-206.

Yeatts, D. E., Cready, C., Ray, B., DeWitt, A., & Queen, C. (2004). Self-managed work teams in nursing homes: Implementing and empowering nurse aide teams. *The Gerontologist, 44*(2), 256-261.

Recruitment Matrix of Recommendations

Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Recruitment					
Develop and implement strategies to attract and recruit into long-term care careers an increasing number of capable, committed, energetic individuals who are called to the opportunities of this employment sector	1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers, consumers, and job seekers:	DLEG led-workgroup with DCH and DHS as partners: convene focus groups of long-term care employers, the single points of entry, and consumers to assess "profiles" of desirable qualities and skills of successful direct care workers, licensed nurses, and social workers, minimally. **A**. Based on those profiles, create materials to introduce and promote the wide variety of career opportunities within long-term care for use by MWA, Work First initiatives, high schools, vo-tech centers, community colleges, etc. B. Based on those profiles and working with people currently employed in the specified careers, create "reality" orientation materials for direct care workers, licensed nurse, and social workers positions including the personal	• 50% increase in successful completion of initial direct care worker training and 50% increase in job retention of direct care worker using MIA materials • 30% increase in LTC employer use of MWA services and 15% increase in LTC employer hiring of Work First participants	Other employers want the resources and referrals from the Michigan Works! Agencies (MWAs). Question: are the needed screening tools unique (enough) to LTC employment. LTC jobs may not meet the job requirements for economic self-sufficiency required by the federal Workforce Investment Act and TANF requirements→ compensation recommendations.	**Within 9 months of acceptance of report.**

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Recruitment— **continued**	1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers, consumers, and job seekers:	elements of "success" in the career C. Based on those profiles and working with people currently employed in direct care workers careers, create screening tools (applications, interview guides, etc.) and protocols for direct care workers positions for use by FIA and MWAs to ensure that only those individuals ready for employment and training in long-term careers are referred to LTC employers and consumers D. In collaboration with LTC trade associations and consumer organizations, inform LTC employers about the reorganized services available through MWAs and FIA for recruitment and screening of potential employees E. After suitable testing, offer the promotional materials, orientation materials, and screening tools and protocols that have been developed to LTC employers and others for their use directly A. Implement the changes in the Michigan Works Agencies systems described			

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Recruitment - continued	2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings:	above with assistance from Work First participants B. Expand post-employment supports for child care, transportation, training, and other supports for Work First participants C. Expand the definition, duration and scope of allowable education and training activities to allow for increased training and education of the LTC workforce, particularly access to college courses that lead to licensed occupations	More qualified Work First participants are recruited for LTC employment. More qualified Work First participants are successfully employed within LTC. More Work First participants employed in LTC continue education to licensed occupations.	Work First participants may have multiple barriers to employment. Old Work First policies did not encourage training before employment. LTC jobs are not competitive with others in the health sector→ compensation recommendations. LTC jobs may not meet the job requirements for economic self-sufficiency required by the federal Workforce Investment Act and TANF requirements→ compensation recommendations.	1 year
	3.Develop recruitment campaigns (in collaboration with the media campaign outlined in the culture change recommendation) to attract men, older workers, and people with disabilities to long-term care careers:	A. Study the research findings (Operation ABLE on older workers) that explain the barriers to long-term care employment of men, older workers, and people with disabilities. B. Conduct focus groups of men, older workers, and people with disabilities to identify barriers to their employment within long-term care. C. Conduct focus groups with LTC employers on the barriers to hiring more men, older workers and people with disabilities.	Creation and broadcast of PSAs and other media. Increased registration for training courses by non-traditional employees. More qualified applicants are men, older workers, and people with disabilities. Increased retention and worker satisfaction.	Negative image of aging, disabilities, dependence and long-term care. LTC jobs are not competitive with others in the health sector→ compensation recommendations	6 months

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Recruitment - continued	3.Develop recruitment campaigns (in collaboration with the media campaign outlined in the culture change recommendation) to attract men, older workers, and people with disabilities to long-term care careers: 4.. Mobilize DCH, DLEG, DHS, OSA, DOE, and other relevant state agencies activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care in all work, projects, studies, and funding related to health care, health care education and training, and career planning: **5. Support employer initiatives to retain and recruit nursing**	D. Incorporate the findings and solution in all recruitment strategies (time frame: 6 months after acceptance of task force recommendation) A. All departments review current initiatives to determine inclusion of long-term care and its career opportunities. (complete within 6 months). B. Create a set of "best practices" for conducting a "health care careers week" for use by MWAs including materials for 6-12 education, community colleges, universities, displaced workers, older workers, and people with disabilities. (See Pennsylvania as an example of activities). C. Incorporate these state agency activities as part of the "culture change" initiative. A. All state efforts and initiatives to expand nursing opportunities should include a long-term care component. B. Reflect the need for	50% of MWAs conduct a "healthcare career week" with participation by 25% of the long-term care employers in events.	Other employers want the resources and referrals from the Michigan Works! Agencies (MWAs). Negative image of aging, disabilities, dependence and long-term care. LTC jobs are not competitive with others in the health sector→ compensation recommendations	1 year

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Recruitment-continued	**professionals within the long term care workforce.**	adequate compensation for nurses involved in long-term care. C. Actively promote opportunities for DCW's to have access to career path options and training to move into the RN, LPN and senior aide level. D. Provide access to distance learning programs for those unable to take traditional college based training. E. Support initiatives to provide tuition support and flexible learning schedules. F. Nursing school curricula should be inclusive of disease specific needs, and gerontology aspects of nursing.	Increased employer activities in keeping with these initiatives. Increased retention. Higher compensation packages even for those businesses serving a private pay marker. Increased training opportunities. More licensed nurses practicing in MI and LTC.	Many kinds of employers are looking for licensed nurses. Preparation of a nurse is a relatively long educational process…years not months. LTC nursing is not "cool"	1 year

Workgroup D:

Retention Matrix of Recommendations

Principle: Builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Retention					
I. **Improve long term care worker job retention to relieve current and future worker shortages, reduce labor-turnover costs, and ensure the most continuous, high quality care and supports.**	1. Create quality long-term care jobs and work environments that engender worker satisfaction .	1. Convene a DCH led workgroup of FIA, DLEG and DOE with employers, worker, and consumer organizations. Workgroup to identify best practices and develop/identify curriculum in : A. Leadership and peer mentor in LTC. B. Internal and external career ladders for LTC workforce. C. A "coaching" approach supervision D. Problem-solving and E. Communications 2. Foster the availability of the identified trainings in colleges and universities, MI Works Agencies, area agencies on aging, CNA approved trainings program, provider associations, etc. 3. Commission research to	▪ Improvement in long term retention of work force; ▪ better training opportunities; ▪ and improved labor relations.	**Barriers:** ▪ Improving image of direct care environment and career potential. ▪ Attracting funding to meet education and training goals. **Address Barriers** ▪ Encourage colleges and universities to offer enhanced training for direct care workers. ▪ Public relations strategies to enhance image of direct care workers.	MDCH-led workgroup convenes within two months of approval by the task force MDCH-led workgroup issues strategies/ guidelines within 6 months of convening

Workgroup D:

Retention Matrix of Recommendations

Principle: Builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
II. **Improve long term care worker job retention to relieve current and future worker shortages, reduce labor-turnover costs, and ensure the most continuous, high quality care and supports**	2. Improve the initial and ongoing training available to direct care workers to allow for enhanced skill development and employability.	examine issues about how the part-time nature of DCW jobs in home care services affects recruitment and retention and how to minimize negative affects on the ability of consumers to access home care services. 1. Expand the 75 hours for CNA required training to include problem-solving, communications, dementia care and other needed topics. 2. MSA remove the cost disallowance for CNA training that exceeds the federally mandated 75 hours. 3. Using the same workgroup described above, explore the creation of a voluntary "universal core curriculum" for direct care workers that includes basic skills and "speciali-zations" such	▪ Improvement in qualifications and educational standards of direct workers. ▪ Retention of qualified and experienced workers in direct care environment.	**Barriers:** ▪ Cost of training and identifying funding sources. ▪ Sufficient teaching facilities and training personnel. **Address Barriers:** ▪ Broaden 'on the job' training, or paid training leave to encourage workers to qualify.	The workgroup convenes within 2 months of approval by the task force. A process for financing and training caregivers is established within 6 months. A process for establishing a registry is established within 3 months of convening the group. The registry is created within 6 months. The wrap-around protocols are developed within 6 months of convening. The Public Health model is developed within 8-10months.

Workgroup D:

Retention Matrix of Recommendations

Principle: Builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
III. **Improve long term care worker job retention to relieve current and future worker shortages, reduce labor-turnover costs, and ensure the most continuous, high quality care and supports**	3. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.	as dementia, end of life, and other services. 4. Foster partnerships with community-based organizations, community colleges, area agencies on aging, and labor unions to delivery the core curriculum. 5. Create a DCW registry that allows credentials workers who have successfully 1. Completed the core curriculum, any specializations, languages, availability to work and other factors to assist potential employers in retaining workers. Create a manual of "best practices" for orienting new employees in LTC settings.Convene a workgroup co-led by MiOSHA and DCH along with employer, consumer, and worker participants to:	▪ New job categories that accommodate older workers and people with disabilities ▪ Broader use of devices and techniques to reduce injury. ▪ Fewer injuries or less serious injuries by LTC workers	**Barriers:** ▪ Cost of training and opportunities for training. ▪ Cost of special equipment to assist with safety issues. **Addressing Barriers:** ▪ Identify cost savings to employers of value of healthier safer	MDCH-led workgroup convenes within two months of approval by the task force MDCH-led workgroup issues strategies/ guidelines within 6 months of convening

Workgroup D:

Retention Matrix of Recommendations

Principle: Builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
		2. Explore methods to restructure jobs to accommodate the older workforce and to attract people with disabilities to LTC services for employment. 3. Access current training methods to prevent injury. 4. Identify devices and techniques to prevent injury while delivering quality services that are not widely used in LTC or whose use is stymied by state policies		workforce.	

Compensation Matrix of Recommendations

Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Compensation					
I. To ensure competitive wages/salary for long term care workers based on their level of education, experience, and responsibilities.	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	**Short-term Wage/Salary:** 1. Using the Lt. Governor's campaign to promote the use of the federal Earned Income Tax Credit by Michigan's low income working families, develop a strategy to engage long-term care employers in an outreach and tax assistance campaign to reach all low-income workers in long-term care. 2. Produce and update annually a resource directory for direct care workers to identify and connect with resources to extend their income. [Examples include one created by Capital Area Community Services Inc. for Clinton, Eaton, Ingham and Shiawassee Counties and one created by Pennsylvania Department on Aging]. • Joint effort of DCH, OSA, DHS, and DLEG in	Increased use of EITC by Michigan residents. Increased promotion of EITC by long-term care employers. Hits on the websites. Numbers of regionally specific resource directories created. Numbers of legislators distributing the resource directory Reductions in the number of uninsured direct care workers.	Reaching low-wage LTC workers is not easy. High cost "refund loans" diminish the dollar value of EITC refund to low-wage workers. Getting resource directory in the hands of direct care workers→ work with employers and worker organizations	**Within 6 months**

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	collaboration with consumer, worker, employer, and • community-based organizations • Put the directory on the web within DLEG, DCH, OSA and DHS identifying it as a resource for direct care workers. • Share the directory template with all who intend to produce a local or regional directory for direct care workers or their employers • Share the template with legislators who intend to issue it regionally 3. Compare entry and average direct care worker incomes to financial eligibility criteria for food stamps, MI Child, WIC and other public assistance programs to assess responsiveness of the public assistance program to meet the needs of direct care workers to support themselves and their families. **Long-term Wage/Salary**	Changes in eligibility criteria to meet needs of direct care workers. Increased use of public benefits by eligible families.	Complexity of task; lack of baseline information about the wages and benefits of direct care workers. Complexity of eligibility requirements. Reluctance of direct care workers to "accept welfare." Reluctance of employers to offer a job and application for welfare. Same as those above.	

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Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	4.　Using the Center on Medicare and Medicaid Services (CMS) *"Return on Investment Calculator: A Tool for Analyzing State Investment in Direct Care Wages"* and any other similar tools, analyze the overall economic costs and economic benefits to the State of Michigan and state programs (Medicaid, TANF, food stamps, child care, etc.) for a state-funded increase in direct care worker wages. [posted at www.hcbs.org] 5.　Re-design Medicaid reimbursement methodologies for all long-term care services to support wage rates that attract a sufficient quantity and quality of individuals to long-term care employers so that services authorized to meet consumers' needs can actually be delivered. Models and elements include: • New methodologies could be based on "living wage" or "economically self-sufficient wage" concept. [Economic Self-Sufficiency in Michigan, A Benchmark for Ensuring Family Well-Being by the	Information that documents the "true" costs of increasing the compensation of publicly funded long-term care workforce. New reimbursement systems that recognize the connection between compensation and retention/recruitment. Higher retention rates. Increased consumer satisfaction. Increased staff satisfaction.	Complexity Political will to address some segment of the uninsured. Complexity. Tension between investing in compensation for the LTC workforce while also investing in more options for consumers.	Within 9 months Within 4 years

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Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Compensation – Continued:	Economic self-sufficiency for paraprofessional staff in all long term care settings. All people working in long term care have wages comparable to the wages of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities	Michigan League for Human Services] • New methodologies could be based on authorizing wage rates that are needed to attract workforce and provide authorized services. [Ball vs. Biedess, U.S. District Court for Arizona, • Mechanisms to insure that authorized wage rates are implemented by employers. • Incentives based on positive workforce outcomes…retention, consumer satisfaction, workforce satisfaction, career ladders and advancement, reduction in use of pool agencies **Short-Term Health care coverage:** 1. Examine the barriers to affordable,	Authorized wages get in the paychecks of employees. Reductions in turnover or use of pool agencies; improvements in retention, staff satisfaction, consumer satisfaction		

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
II. To provide comprehensive affordable health care coverage for workers and their families.	All people working in long term care have access to health care coverage comparable to the coverage options of other people working in health care (e.g. hospital) based on their level of education, experience and responsibilities Stabilize and support employers who are offering affordable health care coverage to direct care workers and their families Utilize existing sources of coverage (Medicare, MI Child Care, third share plans, Veterans) as an interim step to provide short-term coverage and learn about the viability of new or enhanced public and employer-sponsored options. Expand the ability of long-term care employers and their part-time long-term care workers to access affordable health care coverage for themselves and their families.	accessible health care coverage for long-term care employers and their workforces within the DCH "Michigan State Planning Grant for the Uninsured" by over sampling both long-term care employers and direct care workers in all analysis conducted by the grant. 2. Compare entry and average direct care worker incomes to financial eligibility criteria for public and private health assistance programs to assess the public assistance programs abilities to meet the needs of direct care workers and their families. 3. Based on the findings in #2 immediately above, expand or target outreach to direct care workers and their employers for MI Child, Medicare, third share plans, Medicaid, and other public/private health care coverage options. 4. Explore the costs and benefits of instituting a Health Insurance Premium Assistance Program (HIPP) [See http://www.cthealthpolicy.org/pubs/premium.htm for a description of the program	Over-sampling of direct care workers and long-term care employers in the DCH state planning grant for the uninsured. Changes in eligibility criteria to meet needs of direct care workers. Increased use of public benefits by eligible families.	Needs of other uninsured populations Complexity Cost Public is unaware of the lack of health care coverage for long-term care workforce.	Within 6 months **Within 1 year**

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Compensation--- **Health care coverage**		and issues considered in CT.] **Long-Term Health care coverage:** 5. Using the information collected in #1 above, re-design Medicaid and other long-term care reimbursement methodologies for all long-term care services to the recognize the costs of affordable health care coverage of the long-term care workforce so that services authorized to meet consumers' needs can be actually delivered. 6. Using the information collected in #1 above, create health care coverage model(s) to address barriers faced by part-time direct care workers and their employees such as "Professional Employer Organizations (PEOs); expanded Taft-Hartley funds, and other pooling strategies 1. Fund a study on the business/employer barriers to funding retirement for direct care workers. 2. Research how other small businesses that employ low income workers present	New reimbursement systems that recognize the connection between compensation and retention/recruitment. Reductions in turnover or use of pool agencies; improvements in retention, staff satisfaction, consumer satisfaction New systems that reduce the numbers of uninsured part-time workers. Higher retention rates, particularly in home care. Study completed that	Needs of other uninsured populations Complexity Cost Public is unaware of the lack of health care coverage for long-term care workforce.	**Within 4 years**

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
III. To promote adequate retirement planning for all employees.	Educate Employees on available programs with an emphasis on portability for employees. Educate employees on the need to plan for retirement and getting an early start.	retirement planning to employees and adapt to reach the direct care worker. 3. Explore the creation of tax and other financial incentives to encourage employers to provide retirement accounts for employees.	identifies barriers and possible remedies		2 years
IV. To create a Michigan business environment in support of long term care employers with an emphasis on small business, i.e. home care agencies.	Tax credits for employers who meet target level of wages and benefits. (Could more equitably implement a wage "pass through" program). Reduce the administrative burden of health insurance coverage to encourage employers to provide health care coverage. Establish an insurance system that promotes access to affordable health care coverage for small business.	1. Review insurance rating systems to promote access to affordable coverage for small business. 2. Convene a health care employer round table with the State and Federal small business administrations. 3. Create a network for small business providers to access assistance with administrative functions such as health care coverage.	Insurance barriers identified and removed.		1 year

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Culture Change Matrix of Recommendations

Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Culture Change					
I. Develop and implement strategies that value contributions of the direct care worker as part of the long term care team in the provision of care, supports and services.	The Department of Human Services (DHS), Michigan Department of Community Health (MDCH) and Michigan Office of Services to the Aging (OSA),to work collaboratively to identify standards and bench marks ensuring that direct care workers (DCWs) are seen as, and have input as, key partners and team members in providing quality care and supports.	1. Convene a workgroup of advocates, consumers (including representatives from disease specific organizations), providers, direct care workers, licensing and complaint staff from all LTC regulatory bureaus (front-line licensing, complaint staff, and surveyors in addition to managers), Medicaid officials and other experts. This group will identify state and federal regulatory barriers and corporate barriers that licensed providers may face in implementing caregiver empowerment within person-centered planning. 2. Set up an MDCH/OSA/DHS workgroup to ensure that education about new goals is available to all relevant state agencies and their employees and train them in best practice strategies to enable direct care workers	Common belief among providers that that the state's entire regulatory system supports the creation and maintenance of quality LTC services that value consumers and their workforce. Common belief among the public that LTC providers support and work to create workplaces that value consumers and the employees who provide care, supports, and services. Increase in people entering the LTC workforce. Reductions in turnover, the use of pool agencies. Increase in consumer, worker satisfaction.	Perceived federal, state and corporate regulatory barriers which: • preclude licensed providers from implementing cultural change in the interests of the consumer; • limit type or method of financing and reimbursement to provider meeting consumer need; • foster resistance to shared power concepts in consumer care.	Within first year.

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I. Develop and implement strategies that value contributions of the direct care worker as part of the long term care team in the provision of care, supports and services.	The Department of Human Services (DHS), Michigan Department of Community Health (MDCH) and Michigan Office of Services to the Aging (OSA),to work collaboratively to identify standards and bench marks ensuring that direct care workers (DCWs) are seen as, and have input as, key partners and team members in providing quality care and supports.	and long term care staff to work as teams to provide quality care and supports. 3. Analyze existing state licensing, survey enforcement and reimbursement practices and protocols to implement enhanced prioritized evaluation of resident participation and empowerment, in person centered planning. 4. Encourage all LTC providers and LTC corporations to be creative in providing quality care, and emphasize that the current federal and state LTC regulations are not a barrier to implementing Eden Alternative ™ best practices including building Greenhouse models, or similar pilot projects as provided in Certificate of Need amendments effective December 8, 2004. 5. Encourage DCWs and LTC staff to participate in professional organizations for support and continued training.	Increased in the use of creative management and workplace practices such as Eden Alternative, Green House, and the development of more models. Increased participation in training events. Establishment/growth of staff associations or organizations.	Bringing culture change to any organization while still delivering services is hard work. Risk taking is hard.	

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
II. Develop and co-sponsor a statewide media campaign to enhance the image of care workers, to attract a diverse work force cognizant of the diverse cultural needs of the array of people receiving LTC supports and working within the LTC field.	The MDCH/OSA/DHS – led workgroup will convene to develop a plan for implementing the following operational steps:	1. Use all media venues and state of the art technology to produce public service announcements, which promote the meaning and array of careers in LTC. 2. Show positive aspects of direct care workers service to seniors and persons with disabilities as a career attracting a living wage. 3. Include in the public service announcement a State of Michigan toll free number and website addresses for information on LTC career opportunities, education and training. 4. Develop media toolboxes for distribution to Michigan's local communities including the Michigan Works Agencies, AAAs, Chambers of Commerce, Community Action Agencies, LTC employers and others.	Creation and broadcast of PSAs and other media. Increased registration for training courses. More qualified applicants. Increased retention and worker satisfaction.	Negative image of aging, disabilities, dependence and long-term care. LTC jobs are not competitive with others in the health sector➔ compensation recommendations.	1 year

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
III. Develop a K-12 curricula and teaching modules which are age appropriate about aging, the impact of disabilities and emphasizing the career ladder opportunities in long term care. Modules should promote understanding and appreciation of culture and diversity and opportunities for positive relationships between long-term care givers and their clients.	Form an inter-departmental/agency, with the Department of Education as lead, including MDCH, DHS, OSA, LTC consumers and providers, local school boards and community foundation to develop age appropriate student curricula.	1. Align the LTC curricula design for all grade levels with general career programs and interactive events to convey clear and positive images of relationships with older adults and people with disabilities. 2. Show an array of LTC professionals working with our elders. 3. Develop curricula which encourage young people to become involved and engaged in relationships with elders and persons with disabilities. 4. Ensure that volunteering in long term care is included as an option for new Michigan educational assessment program financial grant awards to students who have to meet the 40-hour high school volunteer requirement. 5. Develop comprehensive long term care orientation training programs for high school and college students that promoter a positive image of all health care workers.	Implementation of the curriculum More connections between k-12 students and consumers of long-term care.	K-12 education has lots of responsibilities now. LTC jobs do not look competitive→ compensation recommendations. Negative image of aging, disabilities, dependence and long-term care.	Within 2 years.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
IV. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings.	Partnering the DOE, MDCH, OSA and DLEG, convene a workgroup to develop the content and oversee its implementation into the curricula within two-three years	1. Mandate relevant curricula content in all health professions to balance emphasis on acute care with increased attention to long term care issues and settings. 2. Commission workgroups of various occupational groups to re-examine health care practice roles in various LTC setting to develop more effective skill-sets and standards of practice roles-environments inclusive of culture change. Include direct care workers, RNs, LPNs, mid-level practitioners, advanced practice nurses; physician assistants, social workers, physicians, physical therapists and occupational therapists. 3. Illustrate the impact of culture change through promoting the inclusion of non-traditional aspects of care giving which include opportunities for consumers to experience day-to-day pleasures, like pet ownership, visiting with children, participating in cultural pursuits. 4. Encourage and support high school and college internships and fellowships that include	Implementation of the curriculum More qualified job seekers excited to work in long-term care. Reduced turnover. Increased consumer satisfaction.	LTC jobs do not look competitive→ compensation recommendations. Negative image of aging, disabilities, dependence and long-term care.	Within 3 years

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
	Partnering the DOE, MDCH, OSA and DLEG, convene a workgroup to develop the content and oversee its implementation into the curricula within two-three years	working with elders and persons with disabilities and job shadowing experiences. 5.　　Mandate all community and four-year college DCW and nursing programs and health care administration degrees to include requirements for learning coaching/ mentoring supervisory methods of team and relationship building.			
V. Create financing mechanisms that support an environment for cultural change and diversity within the, workforce.	MDCH, OSA, DHS, providers, and consumers identify funding to use as seed money for establishing LTC staffing best practices that can be piloted and shared across Michigan and the LTC continuum.	1.　　Identify and foster financial incentives for providers producing positive outcomes directly linked to direct care worker empowerment as part of person-centered planning. 2.　　Establish culture change best practices and positive outcomes, which can be studied through funded research to demonstrate and quantify the improvements, cost and benefits of care delivered to consumers across the continuum, and in all LTC settings. 3.　　Develop strategies to implement a 'return on investment' calculator compensation for private	Change in reimbursement systems that support culture change.	Cost Complexity	Within 3 years

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Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
		corporations as an incentive to show the effect on the workforce including tax-based incentives.			

Workforce Projections Matrix of Recommendations

Principle: Michigan builds and sustains culturally competent, highly valued, competitively compensated and knowledgeable long term care workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices.

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
Workforce Projections					
I. **Initiate comprehensive, baseline data of current LTC workforce, across the continuum and in all LTC settings.**	1. Evaluate ways to collect data on the work force across all LTC settings from existing state and federal data bases and in addition to DLEG activities, related to the long term health care workforce. 2. Identify methods to avoid overlap across categories and inclusion of outdated material. 3. Identify state agency to be responsible for ongoing collection and analysis of occupational data relating to long term care sector. 4. Identify ways to track number of employers and their employees, licensed and unlicensed to provide full picture of availability of long term care work force.	Working with DLEG's Bureau of Labor Market Information and Strategic Initiatives: 1. Develop comprehensive, universal system for data collection that can be used in all LTC settings. (Adult Foster Home, Home care, Hospice, Homes for the Aged, long term care facilities, consumer directed). 2. Ensure that data collection is inclusive of a wide range of demo-graphics relating to age, gender, educational attainment, family composition and household income. 3. Seek to collaborate with other states like North Carolina and Ohio who have proven methods of data collection, dissemination and planning based on	Use of data to deliver services, define state policies and activities and influence employer workforce activities.	Complexity of data and resources. Inexperience with data retrieval, analysis and publication	1 year

Goal	Strategies	Operational Steps	Success Measures	Barriers/Address Barriers	Time Frame
		workforce characteristics. 4. Develop methods to identify disease specific, rehabilitative and age specific long term care work force needs. 5. Develop methods to identify future consumer preferences in the long term care continuum.			
II. **Identify method to determine and project disability and rates of disability within the population.**	1. Evaluate current state and federal databases to utilize information to establish rates of disability within population. 2. Identify state agency to be responsible for ongoing collection and analysis of data relating to disability rates within the population	1. Develop method to be either added to existing data collection, or to be stand alone tool to identify rates of disability within population, by age, gender, geographic location, specific disability needs. 2. Distribute current and projected rates to DCH, FIA, OSA, DLEG for planning purposes. 3. Post data on public websites.	Use of data to deliver services, define state policies and activities and influence employer workforce activities.	Complexity of data and resources.	1 year